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	295063	A. BUILDING _____ B. WING _____	04/24/2009

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BATTLE MOUNTAIN GENERAL HOSP	535 S. HUMBOLT STREET BATTLE MOUNTAIN, NV 89820

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on April 21, 2009 through April 24, 2009 and in accordance with 42 CFR Chapter IV Part 483 Requirements for States and Long Term Care Facilities. The census was 16 residents. The sample size was 7 current residents, 1 closed record and 9 unsampled residents. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified.	F 000		
F 371 SS=B	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to maintain sanitary conditions for storing and distributing food.	F 371		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 371	Continued From page 1 Findings include: An inspection of the facility's kitchen and food service operations revealed the following: Sanitizers: On 4/21/09, a pH test kit was not available to accurately measure the concentration of the sanitizing solution in the wiping cloth buckets. Date marking: On 4/22/09 at 3:00 PM, small containers of cottage cheese were observed prepared by kitchen staff, and were delivered to residents on a snack tray. The containers were labeled with a date of 5/3/09. At 3:30 PM, the cook and the dietary manger were interviewed. The cook reported that she wrote the date of 5/3/09 to reflect the "best by" date on the original cottage cheese container. The dietary manager acknowledged that this food dating procedure did not match the kitchen's policy of labeling potentially hazardous foods with the date the original container was opened. Toxic materials: Observation revealed a box of jugs containing a de-limer solution in the dry storage room. The dietary manager indicated the box was being kept there temporarily, as the room could be locked. The facility's written policy dated 8/9/06, titled Infection Control for Food Service Department, under section 12. D, indicated the following: "Insecticides, sprays, and cleaning supplies are stored separately from food products and disposable supplies." Maintenance: The door handle of the walk-in refrigerator was damaged and in need of repair.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES	F 425		

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F 425	Continued From page 2 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview, the facility failed to ensure there were processes in place for accurately identifying, evaluating and addressing the prevention of medication errors for 2 of 8 sampled residents (#2, #7) and for 3 of 9 unsampled residents (#10, #11, #12); the safe disposition and disposal of un-used portions of medications; the returning and destroying of discontinued medications; and that the crushing of medications and opening of capsules was evaluated and approved prior to administration for 2 of 8 sampled residents (#4, #5). Findings include:	F 425		

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F 425	Continued From page 3 On the morning of 4/23/09, during the medication pass observation, Licensed Practical Nurse (LPN) #6 was observed obtaining multiple prescription strength medications from multi-dose bottles out of the house stock drawer. The LPN was then observed reviewing the medication administration records (MAR) and splitting several of the prescription strength tablets in half to meet the dosage requirements that were needed. The LPN was observed disposing of the remainder of the divided tablets into a trash bag receptacle which was mounted to the side of the medication cart. In one situation, the LPN was observed splitting an individually packaged 20 milligram (mg) Lasix tablet in the packet to meet the 10mg dose that was needed. The LPN then discarded the package with the remaining 10mg of Lasix into the trash bag. The LPN indicated that she had been directed to and routinely discarded any split doses, including those in individual packaging. Observation revealed, after preparing the medication(s) the LPN #6 locked the cart, left the cart in the hallway and entered either the dining room or a resident's room to administer medications. When the LPN left the cart to administer the medications (med), the med cart was placed in the hallway in close proximity but was not always within the nurse's view. The contents of the trash bag, including the discarded portions of the divided medications were both viewable and within reach of visitors, staff and other residents passing by. During the med pass observation for Resident # 5, LPN # 6 was observed crushing the resident's morning medications. Review of the MAR did not specify that the medications should be crushed.	F 425		

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The LPN indicated that she routinely crushed Resident #5's medication for ease of administration.

During the the med pass observation for Resident #4, LPN #6 opened the resident's Depakote capsule and mixed it in pudding for administration. The MAR lacked indication or direction that the Depakote capsule should be opened. The LPN indicated it was at the family's request that the medication be opened.

When LPN #6 was asked if the medications had been reviewed for alteration of the drug form (crushing, opening capsules) by the nurse, the physician or the pharmacist, and if it had been approved by the physician, the nurse indicated she had not reviewed the medications for this purpose. The nurse was not sure if it had been reviewed by the physician or pharmacist and indicated there was no doctor's order to crush or open the medications as had been observed during the med pass.

Review of Resident #4 and #5's medical records, including the physician's orders, physician's progress notes and pharmacy consultant notes failed to reveal evidence of a review of the manufacturer's specifications or an approval from the physician to crush medications or open capsules.

Following the medication pass observation, in the presence of LPN #6, the medication cart was inspected and revealed a discontinued medication of Promethazine 25 mg tablets in unit dose packaging for Resident #4. The dispense date on the prescription label was 6/10/08. Review of Resident #4's doctor's orders revealed

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the Promethazine was discontinued on 11/5/08. The LPN indicated that discontinued medications were kept on the med cart until the pharmacist came in, and the pharmacist removed the discontinued items from the cart at that time. The LPN indicated the pharmacist came in once a week. The LPN also indicated Resident #4's discontinued medication was still on the cart because the family obtained the resident's medications from their own source and would be returned to the family. When asked how often the family came in, the LPN indicated that they came in at least weekly, if not several times during the week. The LPN further indicated she was not certain if there was a written policy for the disposition of discontinued medication.

Continued review of the house stock drawers on the medication cart revealed the following prescription strength medications in multi-dose bottles that were currently being used by the facility:
Nifedipine ER 60mg - antianginal, used for hypertension stable angina pectoris
Fluoxetine 10mg - antidepressant, used for treatment of depression
Metformin 1000mg - antidiabetic oral agent, used for diabetes type II
KlorCon 8 ER - potassium replacement, used for hypokaliemia
Premarin 0.625mg - hormone replacement
Armour Thyroid 1/4 grain - thyroid hormone replacement
Lanoxin - cardiovascular agent, used for congestive heart failure, etc.

Review of all of the current residents' medication orders revealed that for five of sixteen residents one or more of the above listed prescription

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strength multi-dose medications were utilized, for Residents #2, #7 #10, #11, and #12. Depending on the dosage requirements, in several instances, medications would need to be split to accommodate the correct dosage.

Review of the facility's policy dated 11/97, titled Administration of Medications specified: "Section II General Policies: A. When ordering any drug the ordering physician and the nurses noting the order must be cognizant of: 4. Monitoring needed-periodic lab work, side effects, effectiveness of therapy; 5. Any requirements of administration included in the package insert such as: C. crushing of med...; G. 1:... Information is recorded as follows: 1. MAR (medication administration record) Name of drug, times and frequency of administration, route of administration and any special instructions."

On 4/23/09 an interview with the facility's Director of Nurses (DON) #2, and the Long Term Care (LTC) Supervisor #3, was conducted. Both the DON and LTC Supervisor indicated that under the current process of using house stock prescription strength multi-dose containers, along with disposing of the remainder of any split doses, it was not possible to evaluate and determine if there were missed does. They further indicated, under the current method there was a greater potential and risk for medication errors. The DON indicated that she had not previously considered looking at this situation from a quality assurance and quality improvement perspective.

When the DON was asked if there was a policy and procedure for the disposition and/or disposing of unused portions of medications, for the crushing of medications, or for discontinued

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medications, the DON indicated there were no written policies.

The DON confirmed that staff were to dispose of the unused portions of medication as had been observed, and discontinued medications were to be left on the med cart until the pharmacist came in, at which time the pharmacist would remove the meds from the cart. The DON indicated it was probably not safe to dispose of un-used portions of medications in the current manner or to retain discontinued medications on the med cart regardless of the type of medication.

On 4/23/09 and 4/24/09, the facility's Pharmacy Technician #7 was interviewed. The technician (tech) indicated that the pharmacist was only at the facility once or twice a week. The technician indicated that if a resident was discharged or expired when the pharmacist was not present, the medication(s) were to remain on the med cart until the following visit from the pharmacist. The technician added that once the pharmacist was available that the medications were then removed by the pharmacist and/or tech.

On 4/23/09, the facility's Quality Improvement Officer #4 was interviewed. The officer indicated that the topic of looking at the current practice of utilizing multi-dose prescription strength medication from a perspective of identifying/evaluating/addressing the prevention of medication errors had not been presented.

On 4/23/09, the facility's Administrator #1, indicated she was not aware of the current practices of utilizing the multi-dose prescription strength medications, the disposal of un-used portions of these medications and the retention of

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F 425	Continued From page 8 discontinued medication on the med cart, but that she understood the potential risks and the possible safety concerns. Cross reference F Tag 431.	F 425		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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This REQUIREMENT is not met as evidenced by:
Based on observation, policy review and staff interview, the facility failed to ensure that prescription labeling of medications was completed for accurate and safe drug administration for 2 of 8 sampled residents (#2, #6) and 1 unsampled resident (#9).

Findings include:

On 4/23/09, the medication cart was inspected in the presence of Licensed Practical Nurse (LPN) #6. Review of the medication cart revealed two opened bottles of Deep Sea Nasal Spray with unsampled Resident #9's name hand written on the top of the bottles. The bottles lacked prescription labels. Review of Resident #9's doctor's orders and medication administration record (MAR) revealed that there was a doctor's order for the nasal spray with accompanying instructions.

Further review revealed one unopened bottle of Chlorhixidine Gluconate 0.12% solution without a prescription label. LPN #6 indicated that the solution was for Resident #2. Review of Resident #2's doctor's orders and MAR revealed there was a doctor's order for the solution with accompanying instructions.

Final review of the medication cart revealed two unopened containers of Advair Diskus 250/50 without prescription labels. LPN #6 indicated there were a couple of residents who used this product and was not sure who it was for.

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Review of all of the facility's current residents' medication orders revealed two of the sixteen residents, Resident #6 and Resident's #9, had doctor's orders with accompanying instructions for Advair Diskus 250/50.

Review of the facility's policy dated May 3, 1007, titled Filing/Labeling Prescription Containers for Dispensing drugs outlined the following:

"Procedure: The pharmacy department shall label all prescription containers containing drugs in accordance with Nevada State Laws. Each label shall contain the following information: 1. Name of the patient, 2. Date the prescription was filled, 3. Name of the drug, strength and rote of administration, 4. Complete specific instructions for use, 5. Physician's name, 6. Expiration date and lot number of the drug, if the drug is not in U/D (unit dose) type packaging., 7. Any appropriate auxiliary stickers that add meaning and information to the prescription."

On 4/23/09 and 4/24/09 the Pharmacy Technician #7 was interviewed. The technician (tech) indicated if the pharmacist was present when a new order was prescribed by the physician for the long term care residents, the pharmacist reviewed the order and instructed the tech to make appropriate labels. The medication was then placed in the med cart. The technician also indicated that if the physician prescribed a medication during the time the pharmacist was not present, the nurse entered the pharmacy and removed enough medication until the pharmacist was available. The technician added that the pharmacist was only at the facility approximately 1-2 times a week.

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F 431	Continued From page 11 On 4/22/09 in an interview with the facility's Pharmacist #8, he indicated he came in once a week and when he came in, one of the things he did was to check the medication carts to make sure things were in order. The pharmacist also stated he reviewed each resident's medical records monthly and made a notation of his review along with any recommendations. Cross reference F Tag 425.	F 431		